Return completed form to Human Resources
Upload to MedHub

NEW HIRE EIT/RESIDENT

Employee ID _____

Group Life Insurance Enrollment

Minnesota Life Insurance Company – A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

UW Employees, Inc. Life Insurance Plan
Policy Number: 33977

1. Check one of the following:
   - ■ University of Wisconsin Hospital & Clinics
   - ☐ University of Wisconsin System

2. Check one of the following:
   - ☒ **Enrollment**: I elect to enroll in this plan.
   - ☐ **Cancellation**: I elect to cancel coverage in this insurance plan. Coverage will terminate on the first of the month after receipt of this form by my employer. I understand if I voluntarily cancel this coverage, I may only reapply with Evidence of Insurability.

3. Return completed form to the Benefits Office.

A. Employee Information			
First name	**Middle initial**	**Last Name**	
Email address			
Street address	**City**	**State**	**Zip code**
Date of birth	**Last four digits of Social Security Number**	**Date of Employment**	**Gender** ☐ **Male** ☐ **Female**

B. Authorization			
I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.			
Employee signature **X**	**Daytime telephone number**	**Evening telephone number**	**Date signed**

For Office Use Only			
Date Received	**Received by**	**Hire Date**	**Coverage Effective Date**
Premium	**Processors Initials**	**Date Processed**	**Employee ID**